PERIOD OF INELIGIBILITY FOR NURSING FACILITY LEVEL-OF-CARE WORK SHEET

For use only when transfers made by an institutional individual occurred on or after January 1, 1990.

Case name: _____

Case number: _____

Eligibility Worker number: _____

Date: _____

REMINDER:

- Do not calculate a period of ineligibility if the month of transfer was more than 30 months from the date for which nursing facility level-of-care under Medi-Cal is being requested.
- Do not add transfers together unless they are transfers made on the same day, from the same account, to the same person.
- The period of INELIGIBILITY can be reduced whenever the institutionalized individual receives additional compensation for the property transferred.
- The period of INELIGIBILITY terminates if the property is transferred back to the institutionalized individual.
- Payments from state-certified long-term care policies are to be deducted from the total net nonexempt property.

A. WAS THE PROPERTY TRANSFERRED EXEMPT OR EXCEPTED FROM INCLUSION IN THE PROPERTY RESERVE AT THE TIME OF TRANSFER? ..... ❒ YES ❒ NO

*If YES, **STOP**. **No period of ineligibility exists.** If **NO**, continue to B.*

B. DETERMINE THE UNCOMPENSATED VALUE OF THE PROPERTY TRANSFERRED. .....

1. Net market value of nonexempt property transferred. ..... _____
2. Amount of compensation received in excess of encumbrances and closing costs. _____
3. Uncompensated value (line 1 minus line 2). ..... _____

C. WAS THE UNCOMPENSATED VALUE OF THE PROPERTY TRANSFERRED LESS THAN THE AVERAGE PRIVATE PAY RATE (APPR)? ..... ❒ YES ❒ NO

1. Uncompensated value (B.3.) ..... _____
2. APPR as of the date of application or the date of institutionalization, whichever is most recent. ..... _____
3. Total (line 1 minus line 2) ..... _____

*If YES, **STOP. No period of ineligibility exists.** If **NO**, continue to D.*

D. IS THERE A POTENTIAL PERIOD OF INELIGIBILITY? (Skip D and continue to E if individual was a Medi-Cal Long-Term Care beneficiary at time of the transfer.) ..... ❒ YES ❒ NO

1. Uncompensated value (B.3.) divided by APPR (round down to the nearest whole number) ..... _____
2. Number of months including month of transfer up to and excluding the month of application or retroactive month, if applicable. ..... _____
3. Total (line 1 minus line 2) ..... _____

*If D.3. is equal to or less than zero, check **NO** and **STOP. No period of ineligibility exists.***
*If D.3. is greater than zero, check **YES** and continue to E.*

E. WAS THE INSTITUTIONALIZED INDIVIDUAL WITHIN THE PROPERTY LIMITS AT THE TIME OF TRANSFER? ..... ❒ YES ❒ NO

1. Amount of other net nonexempt property available to the institutionalized individual at the time of transfer. Note: If an applicant is an institutionalized spouse with a community spouse, include the net nonexempt property available to the community spouse. ..... _____
2. Uncompensated value of property transferred (line B.3.) ..... _____
3. Total net nonexempt property (add lines 1 and 2) ..... _____
4. Enter $2,000. (If the applicant is an institutionalized spouse with a community spouse, include the Community Spouse Resource Allowance (CSRA) in effect at the time of application in addition to the $2,000.) ..... _____
5. Uncompensated value which would have resulted in excess property, transferred to establish eligibility (line 3 minus line 4). If greater than amount in line 2, enter amount in line 2. ..... _____

*If amount is $0 or less, check **YES. STOP. No period of ineligibility exists.***
*If amount is greater than zero, check **NO**—continue to Section F.*

F. PERIOD OF INELIGIBILITY FOR NURSING FACILITY LEVEL-OF-CARE.

1. Uncompensated value of transferred property that would have resulted in excess property (line E.5.)..... _____
2. APPR..... _____
3. Number of months in the period (line 1 divided by line 2, round down to nearest whole number)..... _____

If less than one, ***STOP. No period of ineligibility exists.***

4. **Applicants:** Number of months including month of transfer and up to and excluding month of application and retroactive month (line D.2.) ..... **Beneficiaries:** Number of months including month of transfer up to and excluding current month _____
5. Months of ineligibility remaining (line 3 minus line 4)..... _____
6. If the number of months remaining in line 5 is greater than zero, the PERIOD OF INELIGIBILITY WILL EXPIRE ON _____ (Begin with the month of application, retroactive month, or current month if the person is a beneficiary.)

G. BENEFICIARIES ONLY: DID THE PERSON RECEIVE MEDI-CAL FOR NURSING FACILITY LEVEL-OF-CARE IN A MONTH THROUGHOUT WHICH A PERIOD OF INELIGIBILITY SHOULD HAVE EXISTED? ..... ❒ YES ❒ NO

If YES, there is an overpayment for nursing facility level-of-care only. A referral is required.

NOTE: ***Prior to sending a Notice of Action*** imposing a period of ineligibility for nursing facility level-of-care:

- Evaluate for undue hardship.
- If undue hardship DOES NOT exist, forward case information to DHS Medi-Cal Eligibility Branch Property Analyst for review.